South Texas Orthopaedic & Spinal Surgery Associates
Record Release Form

Arvo Neidre, M.D.   John S. Toohey, M.D.   Guy R. Fogel, M.D.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy guidelines.

TO: ____
____
____

I hereby authorize you to release to:

Dr. ____

9150 Huebner Rd., Ste. 350
San Antonio, TX 78240-1551
Phone (210)561-7234/ Fax (210)561-7240

Description of information to be released, including dates:________________________
____

Purpose of use and disclosure of patient information:______________________________
____

The patient or representative must read and initial the following statements:

1. I understand that this authorization will expire on ___/___/___ (DD/MM/YY). If I fail to specify an expiration date, this authorization will expire 12 months from the date signed. **Initials**__________
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I choose to revoke, it will not have any effect on any disclosures made prior to receipt of the revocation. **Initials**__________
3. I understand that I may refuse to sign this form and that my healthcare and the payment for my healthcare will not be affected. **Initials**__________

________________________________   ____________
Signature of patient or representative   **date**

If a patient's representative signs the authorization, please complete the following:

____
printed name of patient's representative

____
relationship to the patient

Describe the representative's authority to act for the patient:
____
____